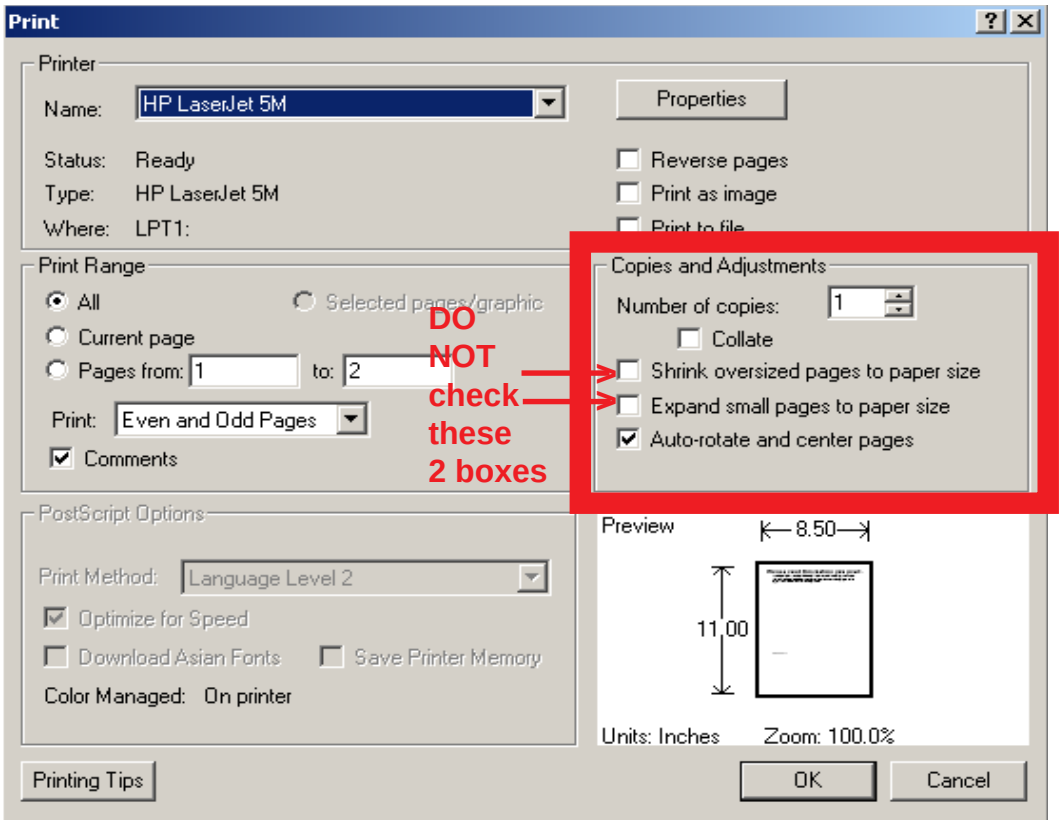
# Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

# A. Contents:

## Registered Counselor License Application Packet

1. 670-034 .. Contents List/SSN Information/Deposit Slip ..... 1 page
2. 670-015 .. Instructions for Registered Counselor Application ..... 3 pages
3. 670-001 .. Application for Registration as a Counselor ..... 4 pages
4. 670-071 .. Registered Counselor Program Credential Verification ..... 2 pages

# B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

# C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

**Cut along this line and return the form below with your completed application and fees.**

## Registered Counselor

# DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

**Please note amount enclosed, and return with your application.**

$ _____

☐ **Check**
☐ **Money Order**

DOH 670-034 (REV 8/2003)

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Washington State Department of Health

# Instructions For Registered Counselor Application

## Application Fee $40.00 (Non-Refundable)

| | |
|---|---|
| Please mail the application, fee and supporting documents to:<br><br>Department of Health<br>Registered Counselor Program<br>PO Box 1099<br>Olympia, WA 98507-1099 | For questions about the application process, please contact our Customer Service Center:<br><br>(360) 236-4700<br>(360) 236-4909 (Fax) |

## Questions and Answers

Q: What is a Registered Counselor and what do they do?

A: Registered Counselors are individuals who provide counseling for a fee. Registered Counselors work in many different settings such as county mental health agencies, chemical dependency facilities, and in private practice. They may employ numerous techniques to assist a client in adjusting their mental, emotional, or behavioral problems. They also work with individuals or groups to achieve sensitivity and awareness of self and others and in the development of human potential.

Some individuals apply for counselor registration while they accumulate required hours for another credential, such as a chemical dependency professional or licensed mental health counselor.

Q: If I've had legal difficulties in the past, how will that impact my ability to obtain a counselor registration?

A: The Department of Health is mandated to protect the health and safety of Washington's citizens. We accomplish that in part, by asking applicants to disclose certain personal information on their application, and by conducting criminal background checks on all new applicants. The application questions are used to help identify individuals that may have a medical condition, substance abuse problem, criminal or credentialing disciplinary history that would limit their ability to practice with reasonable skill and safety. Criminal background checks are conducted through the Washington State Patrol and/or Superior /District Court Information Systems. Both arrests and convictions (whether deferred, dismissed or reduced) will appear on the background check. Please be aware that you must disclose all violations, including: Driving under the influence, driving with a suspended or revoked license, violation of a protection order, and domestic violence.

It is important to know that a "Yes" answer to a personal data question or the existence of a criminal conviction does not automatically prohibit the Department from issuing a credential. Each application is evaluated on an individual basis. We may be able to issue a conditional or restricted credential. Here are a few examples:

**Example #1:** An applicant for a counselor registration was convicted of driving under the influence two years ago. The individual submits certified court documents showing all court requirements have been satisfactorily completed. A treatment discharge summary is submitted from the individual's chemical dependency treatment provider indicating both inpatient and outpatient treatment was satisfactorily completed. The applicant submits their personal explanation of the conviction and the steps they currently use to maintain their sobriety.

Outcome: The applicant was issued a conditional registration restricting their practice to a DASA facility, their employment supervisor must submit quarterly report to the Department, and the applicant must reimburse the costs of investigation and adjudication.

**Example #2:** The applicant's criminal background check revealed several recent convictions for drug related arrests and one for theft. The individual has not completed the court requirements nor have they completed substance abuse treatment.

Outcome: The application would be denied. The applicant would be allowed to reapply only when they complete the court requirements, including the substance abuse treatment recommended in their evaluation.

**Example #3:** The applicant provides court documentation of conviction of a sexual offense. He has completed his prison term and must register as a sex offender.

Outcome: The application is denied.

## Application Information

In order to obtain a credential to practice as a Registered Counselor in the state of Washington, you must:

- Submit a completed application along with your personal explanation and documentation of any "yes" answers to the personal data questions;
- Complete four (4) hours of AIDS/HIV training;
- Submit the $40.00 application fee; and
- Verify other credentials held in this or in other states.

Once these materials are received, your file will be reviewed, and your eligibility will be determined. If there are any deficiencies, you will be notified in writing. If there are no "yes" answers to the personal data questions or no criminal convictions on the background check, you can expect to receive your counselor registration in three to four weeks. If there are "yes" answers or criminal convictions, you can expect a six to nine month wait until a decision is made on your application. That time period may be shortened by your providing current information about convictions, probation compliance, treatment status, etc. If the Department needs to send an investigator to obtain those materials, it adds time to processing your application and adds additional reimbursement costs.

## Special Note to Chemical Dependency Trainees

Persons in training to become a Chemical Dependency Professional (CDP) are required to be registered, certified, or licensed by the Department of Health before beginning an internship, experience placement, or training in a Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) certified treatment agency.

Please keep in mind that all applicants (including Chemical Dependency Professional Trainees) must receive their DOH registration or license before practicing.

# Application Instructions

Please follow these instructions when completing your application. Review it for accuracy and completeness before submitting it to the Department. We ask that you wait at least three to four weeks before contacting this office for information on your application status—your cooperation allows us to process more applications serving all of our customers more efficiently.

**1. Demographic Information**

Information should be typed or printed clearly. Provide your name and address as you would like it printed on your registration. Applications cannot be processed without a birth date and social security number. Keep this office informed of any address change you may have.

**2. Previous Certification/Licensure/Registration**

Please list all health care provider credentials held in this or any other state or jurisdiction. Forward the Credential Verification Form to those states or jurisdictions in which you have held or hold a credential, even it if has now expired. This form may be duplicated. Please note that some states or jurisdictions may charge a fee for this service. Contact that state for more information.

**3. Title Description**

Give a brief description of your therapeutic orientation, discipline, theory, or counseling methods in the Title Description section. Indicate if you are a CDP Trainee.

**4. Personal Data Questions**

Please provide documentation and your explanation for all ”yes” answers to the personal data questions. Documentation may include certified court judgment and sentence, current treatment status, decisions, orders, agreements and surrenders are required and must be included with the application. Failure to respond to any of the questions will delay the processing of your application.

**5. Aids Education And Training Attestation**

Please read carefully the AIDS education and training attestation. After you have completed a minimum of 4 hours of AIDS education, sign and date the attestation.

**6. Applicant’s Attestation**

After you have familiarized yourself with the statutes cited in your lawbook, sign and date the attestation.

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Washington State Department of Health

Health Professions Quality Assurance
Counselor Programs
P.O. Box 1099
Olympia, WA 98507-1099

| For Office Use Only | |
|---|---|
| REGISTRATION NO: | REG. DATE: |
| APPROVED BY: | |
| VALIDATION INFORMATION: | |

REGISTRATION #

# Application For Registration As A Counselor

**Please Type or Print Clearly—**All sections must be filled out before we can process your application

## 1. Demographic Information

| APPLICANT'S NAME LAST | FIRST | MIDDLE INITIAL |
|---|---|---|
| | | |

MAILING ADDRESS

| CITY | STATE | ZIP | COUNTY |
|---|---|---|---|
| | | | |

NOTE: Your registration document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

| TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.) | SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — — |
|---|---|
| | |

| GENDER | BIRTHDATE (MO/DAY/YR) | PLACE OF BIRTH |
|---|---|---|
| ☐ Female ☐ Male | | |

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

## 2. Previous Certification/Licensure/Registration

List all states (including Washington) where certifications/licenses/registrations are or were held.

| STATE | CERTIFICATION/LICENSE TYPE | LICENSE/REGISTRATION/CERTIFICATION | | METHOD OF LICENSURE | | |
|---|---|---|---|---|---|---|
| | | YEAR ISSUED | NUMBER | EXAM | END | GF |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 3. Title Description

Give a brief description of your therapeutic orientation, discipline, theory, or technique. Will you be working as a chemical dependency Professional Trainee? ☐ Yes ☐ No

## 4. Personal Data Questions

| | YES | NO |
|---|---|---|
| 1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. | ☐ | ☐ |

**"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

| | | |
|---|---|---|
| 2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. | ☐ | ☐ |

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Chemical substances"** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

| | | |
|---|---|---|
| 3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? | ☐ | ☐ |
| 4. Are you currently engaged in the illegal use of controlled substances? | ☐ | ☐ |

**"Currently"** means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

**"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

**Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.**

| | | |
|---|---|---|
| 5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with: | | |
| a. the use or distribution of controlled substances or legend drugs? | ☐ | ☐ |
| b. a charge of a sex offense? | ☐ | ☐ |
| c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) | ☐ | ☐ |
| 6. Have you ever been found in any civil, administrative or criminal proceedings to have: | | |
| a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? | ☐ | ☐ |
| b. committed any act involving moral turpitude, dishonesty or corruption? | ☐ | ☐ |
| c. violated any state or federal law or rule regulating the practice of a health care professional? | ☐ | ☐ |
| 7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. | ☐ | ☐ |
| 8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? | ☐ | ☐ |
| 9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? | ☐ | ☐ |

## 5. AIDS Education and Training Attestation

I certify I have completed the minimum of 4 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

| APPLICANT'S INITIALS | DATE |
|---|---|
| | |

## 6. Applicant's Attestation

I, _____ , certify that I am the person described and
NAME OF APPLICANT

identified in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my registration to practice in the State of Washington.

Signature of Applicant_____ Date _____

**Official Use Only**

**Washington State Records Center**

Washington State Department of Health
Health Professions Quality Assurance
Counselor Programs
P.O. Box 1099
Olympia, WA 98507-1099

# Registered Counselor Program
# Credential Verification

## To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been credentialed. Instruct them to return the form directly to the address listed below. Make a copy of this form if you are or have been credentialed in more than one state and/or jurisdiction. Credentialing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process.

| NAME: LAST | FIRST | MIDDLE |
|---|---|---|
| MAILING ADDRESS: | | |
| CITY | STATE | ZIP CODE |
| ANY OTHER NAMES USED: | | |
| CREDENTIAL NUMBER: | DATE ISSUED: | |

Have the licensing agency return this completed form to:

Department of Health
Registered Counselor Program
PO Box 47869
Olympia, WA 98504-7869

If you have any questions, please call (360) 236-4901.

(over)

## (To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

| | | |
|---|---|---|
| NAME OF CREDENTIAL HOLDER: | | |
| AUTHORITY PROVIDING VERIFICATION: (STATE, NAME & TITLE) | | |
| APPLICANT WAS CREDENTIALED BY:<br>☐ Written Examination | DATE: | SCORE: |
| NAME OF EXAMINATION: | | |
| ☐ Other Examination | DATE: | SCORE: |
| NAME OF EXAMINATION: | | |
| Is credential current: ☐ Yes ☐ No | Expiration Date: | |

Is this individual considered to be in good standing in your state? ☐ Yes ☐ No

If "no", please attach explanation.

Has this credential ever been denied? ☐ Yes ☐ No
Suspended? ☐ Yes ☐ No
Revoked? ☐ Yes ☐ No
Surrendered? ☐ Yes ☐ No
Reinstated? ☐ Yes ☐ No

If "yes", please provide a copy of the final order or other documentation of action taken.

If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No

SIGNATURE:

TITLE:

(SEAL)

DATE: